

**State of Oklahoma
Oklahoma Health Care Authority
Clotting Factor Replacement Dispensing**

Pharmacy NPI: _____
Pharmacy Name: _____

Pharmacy Phone: _____
Pharmacist Name: _____

Pharmacy Fax: _____

Dispensing Information

Patient Name*	SoonerCare ID	Date Dispensed	Prescriber Name	Product	Prescribed Dose	Units per Vial	Number of Vials	Units per Dose [‡]	Type of Treatment [¥]	Proof of Delivery [†] (Y or N)

*Can be used for more than one patient

‡If more than 1 vial per dose please indicate vials to be given to make one dose (example: 1092 unit vial + 576 unit vial = 1668 units per dose)

¥P=Prophylaxis, E=Episodic, B=Breakthrough, if breakthrough please specify date of last breakthrough bleed

†Proof of delivery should consist of member or caregiver's signature stating the product was received and should be dated

Pharmacist Signature: _____ **Date:** _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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